DOCUMENT RESUME

ED 325 790 CG 022 948

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TITLE Psychologists-In-Training as Patient Suicide Survivors: A Preliminary Report.
PUB DATE 14 Aug 90
NOTE 17p.; Paper presented at the Annual Convention of the American Psychological Association (98th, Boston, MA, August 10-14, 1990).
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Coping; *Counselor Client Relationship; *Emotional Response; Graduate Students; *Grief; Higher Education; *Patients; *Psychologists; Stress Variables; *Suicide

ABSTRACT

This study was an investigation of the incidence, impact, and methods of coping with patient suicide during the training years of psychology graduate students. A survey was conducted of 54 interns in Clinical Psychology at the Boston Veterans Administration Hospital from 1983 through 1988. The findings revealed that one in six subjects had experienced a patient suicide during their training years. Eight of the nine trainees who had experienced a patient suicide and 10 former trainees who reported a patient suicide attempt completed two copies of the Impact of Event Scale (IES): one with reference to the 2 weeks following the patient suicide or suicide attempt and a second with reference to the 2 weeks immediately preceding completion of the scale. Trainees who had experienced a patient suicide reported stress levels on the IES equivalent to patient reference samples with bereavement, and higher than professional clinicians with patient suicide. Trainees who experienced a patient suicide attempt also reported initially feeling high levels of stress. No significant difference was found on the IES ratings between the Patient Suicide Group and the Patient Suicide Attempt Group. Most frequently, trainees turned to supervisors for support and formulation of the suicide. Preparatory efforts via suicide education were found to be minimal and inadequate. (Author/NB)

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Psychologists-In-Training as Patient Suicide Survivors:

A Preliminary Report

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CG022948

Paper presented at a poster session at the annual convention of the American Psychological Association, Boston, Massachusetts, August 14, 1990

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Psychologists-In-Training as Patient Suicide Survivors:

A Preliminary Report

Abstract

This study was an investigation of the incidence, impact, and methods of coping with patient suicide during the training years of Psychology graduate students. Fifty-four Interns in Clinical Psychology at the Boston VA from 1983 - 1988 were surveyed. One in six subjects had experienced a patient suicide during their training years. These trainees reported stress levels on the Impact of Event Scale equivalent to patient reference samples with bereavement, and higher than professional clinicians with patient suicides. Most frequently, trainees turned to supervisors for support and formulation of the suicide. Preparatory efforts via suicide education were found to be minimal and inadequate.

Psychologists-In-Training as Patient Suicide Survivors:

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Summary

Brown (1987a, 1987b) is to be credited with creating the greatest impetus to date to a more systematic study of the impact of patient suicide on mental health professionals-in-training. In his sample of Psychiatric Residents, he estimated that 1 in 3 Residents had a patient commit suicide during their Residency years. His study, however, as well as preceding studies, have primarily involved Residents in Psychiatry. The present study, which parallels Brown's study, represents an effort to collect data on the incidence and impact of patient suicide on Psychology graduate students while in clinical training.

Brown (1987a) has also suggested a system of Training Program responses to help the professional-in-training to cope with the impact of a patient suicide. In the present investigation, an attempt is made to collect data on what Psychology Trainees/Interns actually have found helpful when confronted with the crisis of a patient suicide.

Subjects. The participants in this study were pre-doctoral Interns in Clinical Psychology at the Boston VA Medical Center during the years 1983 - 1988. Each of the 54 former Interns had spent a year at the Boston VA. Overall, the group had a mean number of 5.2 years (SD = $\pm$ 1.06) of participation in a graduate level Clinical or

Counseling Psychology Program (i.e., up to and including the Internship year). Their mean age was 34.0 years (SD = ± 4.55).

Method. In Phase I of the study, the former Interns were surveyed by telephone. They were asked a series of questions designed to identify the experience of patient suicides or patient suicide attempts during their training years. In Phase II, each respondent who reported a patient suicide or a patient suicide attempt was asked to complete the Impact of Event Scale (IES) (Horowitz, Wilner, and Alvarex, 1979). This scale is a measure of subjective stress associated with a specific event. Each respondent was mailed two copies of the scale to fill out: one with reference to the two weeks following the patient suicide or suicide attempt (Form I), and a second with reference to the two weeks immediately preceding completion of the IES (Form II). The mean time elapsed between the patient suicide or suicide attempt and completing the IES was 5.4 years and 4.0 years respectively.

In Phase III, each of the respondents who reported a patient suicide completion was interviewed by telephone using a semi-structured format. The purpose of this interview was to assess what resources the subjects used to cope with and recover from the impact of the event. The interview covered four major categories: (A) utilization of support systems; (B) contact with the patient's family; (C) post-suicide reviews; and (D) suicide education/training.

Results. All fifty-four (100%) of the Boston VA Interns from 1983 - 1988 were contacted and participated in the Phase I survey on incidence. Nine (16.7%) reported having had a patient commit suicide during their training years. This is a 1 to 6 ratio.

There were no significant differences in sex, age, or years of training for subjects who experienced a patient suicide versus subjects (N = 35) who had not experienced either a patient suicide or suicide attempt.

In Phase II of the study, eight of the nine former Trainees[1] who had a patient suicide and ten former Trainees who reported a patient suicide attempt completed the two forms of the IES. The data were analyzed in three 2 x 2 (Group x Time) analyses of variance with repeated measurements on the time factor. The three ANOVAs were with Intrusion scores on the IES, with Avoidance scores, and with the Total or combined Intrusion and Avoidance scores.

In all three ANOVAs, the only significant effect was a main effect for Elapsed Time. An inspection of the IES means for time since event indicated that there was a clear improvement in the stress level associated with a patient suicide or suicide attempt over time. The main effect of Group and the interaction effect of Group x Time, however, were not significant. The mean scores for the Patient Suicide group and the Patient Suicide Attempt group in regard to the two weeks after the event were as given in Table 1, and suggest that both groups experienced clinically high levels of stress.

There is some accumulating IES reference data against which we can judge the stress level in our sample. A comparative look at Table 2 indicates that our group of former Trainees who experienced a patient suicide reported Intrusion and Avoidance scores close to the scores given by patient samples who experienced bereavement or personal injury (Cf. Horowitz et al., 1979; Zilberg, Weiss, and Horowitz, 1982). Moreover, their stress levels seem higher than those reported by Chembtob, Hamada,

Bauer, Kinney, and Torigoe (1988a, 1988b) for professional level Psychiatrists and Psychologists who experienced a patient suicide. On the other hand, the group of former Trainees who experienced a patient suicide attempt reported mean Intrusion and Avoidance scores equal to the professional level clinicians who actually had a patient suicide and equal to a non-patient sample who had experienced bereavement (Cf. Zilberg et al., 1982).

Eight of the nine former Trainees who experienced a patient suicide were interviewed at greater length to assess how they coped with and recovered from the impact of such an event. The results of the interview are summarized in Table 3 under the four categories noted under Method above.

A. Utilization of support systems. Of the four categories of support, discussion with supervisors was clearly rated as most supportive to the Trainee. Receiving support from peers (i.e., other Trainees) and from agency staff were also perceived positively; however, two respondents reported a fear of being judged negatively by peers. Support from their own family members was rated somewhat less positively.

B. Contact with the patient's family. Seven of eight former students (88%) had some form of direct contact with the patient's family following the suicide. Interview comments indicated that subjects felt relieved to find that family members were not ascribing blame to them, and/or they felt good about being able to offer support to the family. Only a few subjects attended funeral services for the patient and they varied widely in their assessment of its helpfulness to them.

C. Post-suicide reviews. Seven of eight former Trainees (88%) reviewed factors leading to the suicide with supervisors. This was rated as quite helpful. Two subjects discussed the suicide with a therapist and found this also beneficial. Mixed reactions were reported by the few subjects who had a case conference or psychological autopsy. Two subjects had an institutional administrative inquiry and found this to be of only minimal benefit.

D. Suicide education and training. Five subjects (63%) reported receiving prior instruction in the epidemiology and understanding of suicide; however, such training was minimal (e.g., at most one or two lectures). The instruction was rated as moderately helpful when subsequently faced with a patient suicide.

Discussion. The finding that 1-in-6 Psychology Trainees/Interns had the experience of a patient suicide suggests that it is not an infrequent event. The 1-in-6 rate for Psychology Trainees, however, is not so high as the 1-in-4 to 1-in-3 ratio reported by Brown (1987a) for Psychiatric Residents in a comparable survey. On the professional level, large national surveys (Chemtob et al., 1988a; 1988b) have found that 51% of Psychiatrist respondents and 22% of Psychologist respondents had a patient suicide during their professional careers. These differences in rate at both the training and professional levels may be attributable to differences in the populations served by the respective disciplines.

As has been found in previous studies with their Psychiatric counterparts, the results of this study confirm that Psychology Trainees/Interns have a strong emotional response to the suicidal death of a patient. IES reference group data (Table 2) suggests

that the impact is stronger for Trainees than for professional clinicians. Those subjects who experienced a patient suicide attempt, however, also reported initially feeling high levels of stress. Possible explanations for the fact that no significant difference was found on IES ratings between the Patient Suicide Group and the Patient Suicide Attempt Group are discussed in this study. Some data pertinent to this discussion has been reported by Rodolfa, Kraft, and Reilley (1988), who did not assess stress associated with patient suicide, but found that patient suicide attempts were rated second only to physical assault as behaviors most stressful to professional and training level therapists.

The findings in the present study support the need for a system of Training Program responses (such as that proposed by Brown (1987a)) to help the clinician-in-training cope with and recover from the impact of a patient suicide. The role of the Trainee's supervisor, both as a supportive figure and as someone most helpful in reviewing and formulating the suicide, seemed pivotal in the coping process. It also seemed helpful to have direct contact with the patient's family, and to find, most frequently, that they were not blaming the therapist and that the therapist could offer support to grieving family members. Prospective methods of preparing graduate students for the possibility of experiencing a patient suicide and of educating them to the epidemiology and understanding of suicide were found to be minimal.

If a training Program were to establish a protocol for aiding Trainees who experience the loss of a patient through suicide, it is recommended that the following two suggestions be given consideration: (1) there seems to be a need for an immediate supportive response to the student to prevent traumatization and minimize isolation;

and (2) there seems to be a need for a safe forum that will allow the student to express his or her feelings, ensure positive learning from the experience, and help the student to integrate it constructively into future work with high risk patients.

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Footnotes

[1]One of these nine former Interns was terminally ill and died before the completion of this study. As a result, data reported beyond the data on incidence of patient suicide is based on a sample of eight (8) rather than nine (9) participants.

Table 1

IES Intrusion and Avoidance Mean Scores

Patient Suicide Group		Patient Suicide Attempt Group	
Intrusion Mean	Avoidance Mean	Intrusion Mean	Avoidance Mean
20.0	13.4	15.5	10.3
(SD = 10.3)	(SD = 6.7)	(SD = 4.3)	(SD = 5.9)

Table 2

Impact of Event Scale Reference Groups

Study	Population	Stressor	Intrusion Mean	Avoidance Mean
Horowitz et al. (1979)	Patients (N = 66)	Bereavement, Personal Injury	21.4 (SD = 9.6)	18.2 (SD = 10.8)
Zilberg et al. (1982)	Patients (N = 35)	Bereavement	21.2 (SD = 7.9)	20.8 (SD = 10.2)
Chemtob et al. (1988a)	Psychiatrists (N = 131)	Patient Suicide	14.3 (SD = 9.1)	10.3 (SD = 9.3)
Zilberg et al. (1982)	Non-Patients (N = 37)	Bereavement	13.5 (SD = 9.1)	9.4 (SD = 9.6)
Chemtob et al. (1988b)	Psychologists (N = 81)	Patient Suicide	13.3 (SD = 9.0)	8.9 (SD = 6.6)

Table 2 continued

Table 2 - continued

Horowitz et al. (1979)	Female Medical Students (N = 35)	Cadaver Dissection	6.1 (SD = 5.3)	6.6 (SD = 7.0)
Horowitz et al. (1979)	Male Medical Students (N = 75)	Cadaver Dissection	2.5 (SD = 3.0)	4.4 (SD = 5.3)

Table 3

Utilization and Rating of Resources for Coping and Recovery (N = 8)

A. Utilization of Support Systems

Type of Support	Percent Reporting	Helpfulness Rating*
Supervisors	100%	4.4 (SD = .85)
Peers	88%	3.5 (SD = .97)
Staff at Facility	63%	3.5 (SD = 1.5)
Family/Significant Others	63%	3.0 (SD = .82)

B. Contact with Patient's Family

Type of Contact	Percent Reporting	Helpfulness Rating
Met/Talked with Patient's Family	88%	3.8 (SD = 1.3)
Attended Wake or Funeral	38%	2.9 (SD = 1.3)

C. Post-Suicide Review

Type of Review	Percent Reporting	Helpfulness Rating
Discussion with Supervisor	88%	4.4 (SD = .82)
Discussion with Therapist	25%	4.5 (SD = .70)
Case Conference/Psychological Autopsy	38%	3.0 (SD = .00)
Administrative Inquiry	25%	2.0 (SD = .00)

Table 3 continued

Table 3 - continued

D. Suicide Education/Training

Type of Education/Training	Percent Reporting	Helpfulness Rating
Instruction in Epidemiology	63%	2.9 (SD = 1.0)
Instruction in Legal Practices	38%	2.7 (SD = 1.3)
Anticipation of Patient Suicide	38%	2.3 (SD = .58)

* The Mean Helpfulness Rating is based on a 5-point scale (1 = Not at all helpful to 5 = Very helpful)